GROUP PSYCHOTHERAPY

INTRODUCTION

Group psychotherapy is a form of structured therapy employed on inpatient and outpatient settings. Most psychiatry residents and interns who rotate on the inpatient and outpatient settings bring with them limited or no experience providing psychotherapy. If you are not nervous about learning to facilitate group therapy, you are probably abnormal: You are the baby being thrown into a pool to learn to swim. Like learning to swim, learning group is something one cannot effectively learn by reading a book. It has to be experienced.

This is meant to be an introduction to inpatient groups. Hopefully, the principles you learn here can be carried forth to longer-term outpatient groups and individual treatments you facilitate.

PURPOSE

Inpatient group is an amoeba – constantly changing form and purpose. This is because length of stays on inpatient units is short. Every day brings a new mix of patients with different backgrounds diagnoses, and intellectual skills. As a result, the group can be quite different form one day to the next. This demands flexibility from the facilitator who must adjust his technique to the group make-up as well as his expectations of the goals to be achieved. Therapeutic goals often achieved through the inpatient group process include:

- Reality testing: Ability to distinguish reality from psychosis.
- Improved socialization: Being able to communicate with one another effectively
- Bolster coping skills a patient already has: Supportive therapy of strengths
- Share experiences to decrease isolation
- Learn new coping skills
- Understanding defense mechanisms and resistances
- Conceptual understanding of group as a microcosm for real life behavior
- Understanding transferences that arise in group and their developmental underpinnings

The above list progresses from relatively primitive to advanced goals. You will find that individual work similarly tends to proceed on such a continuum. It is often referred to as the supportive to expressive continuum. In group, the

individual members will be somewhere along this continuum and the composite group will fall somewhere on this spectrum. For example, a group might have an actively psychotic schizophrenic patient, an Airman Basic with an adjustment disorder, and a neurotic person with depression. The group as a whole often functions at the level of the lowest functioning member. For instance, in the example group, the group may have to focus on reality testing for the delusional schizophrenic patient. The other members may individually be working on higher-level goals. For instance, the Airman Basic might be able to relate his confusion that arose in Basic Military Training to the confusion the schizophrenic patient experiences. Similarly, the neurotic patient may be able to see how the schizophrenic patient's misinterpretation of ongoing experience is similar to his own misinterpretation of current relationship problems based on his developmental history of being raised in a family where his father beat his mother.

GROUND RULES

We have tended to use a set of guidelines to provide some structure to group and help at making the group productive. Here are some common rules used in inpatient groups:

1. Use "I" statements: Ex. "I felt sad when my wife told me she wanted a divorce." Vs "You feel sad when your wife tells you she wants a divorce." The first statement forces the patient to own the feelings and focus on his own circumstances.
2. "What's said in group stays in group." Confidentiality of the group material is important to emphasize especially when two groups are running.
3. Stay in the "Here and now": This rule is a bit hard for many group members and facilitators to grasp. What is really meant is to focus on what is happening in group. What it is interpreted as is to focus on the things, which have brought you to the hospital. I find it acceptable to allow the second interpretation. I often add a caveat that members can bring up the past as it relates to the present.
4. "Eye contact": Maintain eye contact with individuals. This emphasizes the relational aspect of group.
5. Bring an agenda to group: Patients are supposed to have an agenda about which they want to talk. Agendas should be focused and appropriate to group. Examples of bad agendas: "I want to talk about getting ward status." "I want to talk about my medications." "I want to

talk about what a jerk my husband is." Examples of the above agendas refocused into good agendas: "I would like feedback from the group about how I am progressing and what I need to work on to make ward status." "I want to talk about what it feels like to need medications for my illness rather than having the strength to get over it by myself." "I want to talk about how my interactions with my husband contribute to my depression."

Other rules and aspects of the structure of group include:

1. People should generally not bring food, drink, or other distracting/anxiety reducing material to group
2. People should give honest feedback
3. Group needs to be a safe place: Limit profanity and physical contact
4. Mention the purpose of the facilitators: To keep group focused
5. Mention the purpose of the observers: To provide feedback to the facilitators to improve the process group
6. The structure of the group usually begins with going over at least the above 5 rules, agendas, and the purposes of the facilitators and observers. Then go around the group and have patients introduce themselves, a brief statement about why they are in the hospital, and state their agendas. Group is then open. Closing group is usually accomplished by having a member summarize the important aspects brought up in group or with the facilitator doing this function.

Please note that the above structure and rules are the traditional way group has been done on this unit. You may experiment with different styles if you wish.

POST GROUP

During post-group, observers should discuss dynamics occurring in group and the strengths and weaknesses seen in facilitator activity. It is important to keep post-group focused on this task. With the varied experience of observers, there is a tendency to comment more on the individual behaviors of patients and less on the process of group. Residents on occasion may feel as though they are being put down or that their skills are being challenged during the post-group process. This can arise from many things including residents feeling vulnerable during the process of learning a new task and thus especially sensitive to criticism, observers getting caught-up in negative countertransference toward certain patients or the group as a whole and projecting some of this onto the

facilitators, outside issues the facilitator or observer has brought with them to work, and conflict between observer and facilitator based on outside of group interactions Whatever the source, just as you do with patients, you will want to try to discern what feedback should be valued and what should be discarded. Since post-group tends to be a large assembly of individuals, I often found it helpful to do a reality check with trusted peers or my supervisor at a later time.

THE GROUP

The group is structured as outlined above. As the facilitator, you will want to begin to take notice of what are commonly termed the *content* and *process*.

Content focuses on what is actually said or done in group. Examples of content are statements actually made from one person to another and behaviors such as bouncing knee, pushing a chair backwards, or remaining silent. Primitive groups tend to be content oriented. More mature groups will use content to understand process.

Process is a much more abstract concept involving the "true" meaning of speech and behaviors both to the individual and the group. It tends to be preconscious or unconscious material. An example of process will hopefully make this concept clearer:

> Group member, A, states to another B: "You need to let go of your resentment of the Air Force." The process may have multiple levels: Group member A may be feeling controlled by his parents and may need to "let go" of his strong need for approval from them. Group member B may have parental transference toward A, and A may be feeding into a projective identification where he is acting like B's father. At the group level, A may be acting as the voice of the group which is bored by B's domination of group time which may be similar to the way B relates to others in his life.

As the example demonstrates, figuring out process involves some speculation by the facilitator since the material is not directly stated. Experience and knowing the background and development of the patients in the group will help you gradually gain skill at being on target with understanding process. Keeping aware of process while being involved in the content work is a difficult skill to develop.

FACILITATOR EXPECTATIONS

It is important to resist the tendency of accepting total responsibility for the rate of progress a patient or group makes. While the physician-patient relationship carries with it some expectation that we will try to help a person heal, remember in psychiatry that most of the illnesses we deal with are chronic and have no cure. Personality and defensive strategies develop over long periods and resistance is a natural aspect of human behavior. Some days a group just does not want to budge no matter what the facilitator does. Other days a group will be exciting and active, and the facilitator will basically only need to observe process. A facilitator who takes on to much responsibility for the progress of the group will soon find himself/herself quite frustrated.

With the above in mind, the basic jobs of the facilitator are to keep the group safe and to try to help patients improve. By keeping the group safe, one needs to intervene if conversation degrades to the point it is harmful or if the threat of violence becomes apparent. It is all right to have angry affect and constructive criticism in group but not threats of physical harm or destructive name calling.

TRICKS OF THE TRADE

While experience is the most likely thing to reduce a new facilitator's anxiety, here are a few trick s to keep in mind that might help as well:

1. Encourage patients to be specific. This is similar to the "I" statement rule in that it pushes a patient to own his experience. Statements like "I felt angry when the TI told me I had screwed up my wall locker – like I was some sort of kid" are much more therapeutic than "You get really angry when someone treats you like a kid." The second statement dissociates the personal experience and thus the affective connection. Generally except in quite psychotic groups, getting patients to display affect while telling experience is cathartic. This is quite true on inpatient groups where mutual understanding and increased interpersonal connectedness is an objective.
2. Try to minimize questions directed to one patient. Ask questions to the group. Instead of commenting on a patient's statement or behavior ask the group to comment. These actions will minimize the one on one activity between therapist and patient and encourage group activity.
3. Ask patients not to speak to you but to another patient with whom they relate. Again, this promotes group interaction.
4. Minimize looking at the person who is talking. Instead look at other group members and facilitators. This decreases dependence on the

facilitator-patient interaction and gives other patients the message that you expect them to speak. It also allows you to check in with other facilitators.

5. Comment when affect and verbal content or displayed behavior do not match up. Confrontation is difficult for beginning providers but essential to the therapeutic process.
6. An occasional "What is going on in the group right now? It is slow." Or "I wonder where people are at?" or "People don't seem like they want to work today" will spur the process if group is slow, and you are not sure what is going on with the group. These kinds of statements produce anxiety, which is an excellent motivator. The trick to these statements is to say them and then allow silence. You do not want to rescue the group from the anxiety you just injected. The silence will be just as anxiety provoking for the new facilitator as it is for the group members, so you must learn to become comfortable with it. These are process statements and may not be fruitful in a particularly primitive group.

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